REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number:_____

You have the right to request the Department of Health Services (DHS) to restrict the use and disclosure of Medi-Cal information to carry out treatment, payment or operations. You also have the right to request DHS not to disclose Medi-Cal information to a family member, relative, or friend involved with care or payment for the individual's health care. DHS may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address. Mail this completed form to:

Department of Health Services
EDS Communications
P.O. Box 526018
Sacramento, CA 95852-6018

INDIVIDUAL FOR WHOM YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
BENEFICIARY ID NUMBER:	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)
DEATH CERTIFICATE MUST BE ATTACHED		

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO RESTRICT USE AND DISCLOSURE OF HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT USE AND DISCLOSURE OF THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

[PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES, OR OTHER IDENTIFIED PERSONS TO WHOM YOU DO NOT WANT DHS TO DISCLOSE INFORMATION.]

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE:_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_____

I UNDERSTAND THE DEPARTMENT OF HEALTH SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

REPRESENTATIVE SIGNATURE: DATE:

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY: _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER: _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.